The Child and Adult Care Food Program
Enrollment Form / Income Eligibility Statement for Adult Day Care

CENTER NAME: _____ FISCAL YEAR: 2016

PART 1 – PARTICIPANT INFORMATION

First and Last Name(s) of Adult Participant(s)	Date of Birth

PART 2 – BENEFITS FROM MEDICAID, SUPPLEMENTAL SECURITY INCOME (SSI), and/or SNAP

If any member of the household receives SNAP (Food Stamp) benefits, or if the adult participant receives Medicaid or SSI benefits, write the recipient's name, circle the benefit type(s), and give the identification or case number.

Name of Benefit Recipient	**Type of Benefit Received** (CIRCLE)	**Identification / Case Number** (REQUIRED)
	MEDICAID SSI SNAP	

PART 3 – TOTAL HOUSEHOLD INCOME – *Not required if you provided an ID or case number in Part 2.*

Write how much income is received by each person in the household **and** report how frequently that amount of income is received: weekly, every two weeks (biweekly), twice a month (semimonthly), once a month (monthly), or annually.

List the name of the adult participant, his or her spouse, and/or any other individuals living with the participant who share income and expenses or depend on the participant for financial support. A functionally impaired adult living with his or her parent(s) is considered a separate household from the parent(s) and does **not** have to list the parent's income.

List Names (First and Last) of **Everyone** In Your Household	Gross Income (before Taxes or Deductions) from Last Month (if none, write "0")							
	Earnings From Work Before Deductions		Alimony, Child Support, Welfare, etc.		Pensions, Retirement, Social Security, VA, etc.		Second job or any other income	
NAME	INCOME	FREQUENCY	INCOME	FREQUENCY	INCOME	FREQUENCY	INCOME	FREQUENCY
1.								
2.								
3.								
4.								
5.								
6.								

PART 4 – CERTIFICATION, SIGNATURE, AND SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

The adult household member who fills out the application must sign below. If Part 3 is completed, the adult signing the form must also provide the **last four (4) digits ONLY** of his/her Social Security Number (SSN), or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) **The last four digits of your SSN are not needed if you have provided an identification or case number in Part 2.**

CERTIFICATION: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution official(s) may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

PRINTED NAME OF ADULT COMPLETING THE APPLICATION	**(LAST 4 DIGITS ONLY)**: XXX – XX – ____ ____ ____ ____ SOCIAL SECURITY NUMBER (SSN) OF ADULT COMPLETING THE APPLICATION	
SIGNATURE OF ADULT COMPLETING THE APPLICATION	DATE	☐ I do not have a Social Security Number
STREET ADDRESS, CITY, STATE, ZIP CODE		DAYTIME PHONE

PART 7 – CIVIL RIGHTS INFORMATION: ENROLLED PARTICIPANTS' ETHNICITY & RACE (OPTIONAL)

Check the ethnic and racial identity of adult participant(s).

Ethnicity (mark one ethnic identity):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more racial identities):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application, and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this Program is administered without discrimination.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, income derived all or in part from any public assistance programs, or protected genetic information in employment or any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete a USDA Program Discrimination Complaint Form, found online at http://ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, DC 20250-9410, by fax at (202) 690-7442, or by email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 977-8330 or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

In conjunction, the District of Columbia Human Rights Act, approved December 13, 1977 (DC Law 2-38; DC Official Code §2-1402.11(2006), as amended) prohibits discrimination on the basis of marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, familial status, source of income, place of residence or business, genetic information, matriculation, or political affiliation of any individual. To file a complaint alleging discrimination on one of these bases, contact the District of Columbia's Office of Human Rights at (202) 727-3545.

PRIVACY ACT STATEMENT

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you list a Medicaid, SSI or Supplemental Nutrition Assistance Program (SNAP) case number or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program. Verification efforts may be carried out through program reviews, audits, and investigations and may include contacting the Income Maintenance Administration office to determine current certification of receipt of SNAP benefits, the Department of Human Services office to determine current certification of receipt of Medicaid benefits, or the issuing office of SSI to determine current certification of receipt of SSI benefits; contacting employers to determine income; and/or checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported.

CENTER USE ONLY – IES CLASSIFICATION

Reimbursement classification category (check one)

- ☐ Free (Medicaid, SSI, SNAP, or Income Eligible)
- ☐ Reduced-price
- ☐ Paid (household income above free or reduced-price level)
- ☐ Paid (incomplete information)

Total Household Income:

If necessary, use the correct income conversion formula before adding incomes reported with different frequencies. Once total monthly income is determined, write "monthly" as the frequency and use the "monthly" column of the Income Eligibility Guidelines.

To find monthly income:

Weekly income X 4.33 / **every 2 weeks** X 2.15 / **twice a month** X 2

Total income: $ _____ Frequency: _____

Number of household members: _____

The institution's Determining Official MUST sign and date the IES to complete it. Signature of a Verifying Official is recommended.

_____ _____

Signature of Determining Official Date

_____ _____

Signature of Verifying Official Date

Date participant(s) withdrew or terminated: _____